HASCAS
Health and Social Care Advisory Service

Executive Summary

Independent Investigation

Into the

Care and Treatment Provided to Mr X

by the Surrey and Borders Partnership NHS Foundation Trust

Commissioned by NHS England

Report Prepared by: HASCAS Health and Social Care Advisory Service
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1. Investigation Team Preface

1.1. The Independent Investigation into the care and treatment of Mr X was commissioned by NHS England pursuant to *HSG (94)27.*[1] The Investigation was asked to examine a set of circumstances associated with the death of Mr Y who died on 30 March 2013, after being punched by Mr X and falling between a train station platform and a moving train.

1.2. Investigations of this sort should aim to increase public confidence in statutory mental health service providers and to promote professional competence. The purpose of the Investigation is to learn any lessons that might help to prevent any further incidents of this nature and to help to improve the reporting and investigation of similar serious events in the future.

1.3. Those who attended for interview to provide evidence were asked to give an account of their roles and provide information about clinical and managerial practice. They all did so in accordance with expectations. We are grateful to all those who gave evidence directly, and those who have supported them. We would also like to thank the Trust's Senior Management Team who granted access to facilities and individuals throughout this process. The Trust's Senior Management Team has engaged fully with the root cause analysis ethos of this work.

2. Condolences to the Family and Friends of Mr Y

2.1. The Independent Investigation Team would like to extend their condolences to the family and friends of Mr Y. We extend our thanks to the family of Mr Y who met with members of the Investigation Team. We hope that this Investigation addresses the questions they have raised.

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1. Health Service Guidance (94) 27

3. Incident Description and Consequences

Background for Mr X

3.1. Mr X was19 years old at the time of the incident. In March 2013 he was living at home with his parents, and working for his father's plumbing engineering business. He had been living at home since November 2012, following the onset of what appeared to be a psychotic episode. This had occurred shortly after starting the second year of his degree at University.

3.2. Mr X's family described him as having an unremarkable childhood, with no major health issues, and achieving well at school. He was a keen footballer, and was noted to be quiet and considerate of others; it was unusual for him to lose his temper. He had no history as far as his parents were aware of getting into trouble, fights or arguments with others. In fact his parents remarked that character statements to the Court from his teachers stated that his nature was calm and considerate and that this was often remarked on.[2]

3.3. It was noted in his clinical records that when at university he shared a house with other students. It was also noted that he was friends with other students who took drugs and drank alcohol heavily. Mr X reported drinking heavily and trying drugs but not being a regular user. In 2010 when on holiday in Greece with friends he became mentally unwell, showing confusion and disorientation, it was suspected this was a result of either alcohol, drugs or both. His parents had to fly out to Greece to return him home. His symptoms were reported by his parents as remitting without any treatment on this occasion.[3]

3.4. In October 2012 Mr X returned home from University with his mother after he had been displaying symptoms of low mood, social disengagement, not attending his lectures, being worried about his post and money, and appearing generally confused, anxious and uncommunicative. His parents took him to his General Practitioner who made a referral to the local specialist mental health services. However prior to this appointment coming through, his parents became so concerned that they took Mr X to his local Accident and Emergency Service. Following being seen and assessed at the Accident and Emergency Service by a mental health nurse, his referral was picked up in the following 24 hours by an Early Intervention in Psychosis Team. This team visited Mr X at home and started treatment with antipsychotic medication. Mr X appeared to respond well to this treatment with recovery from his symptoms evident over the following two weeks.[4]

3.5. In March 2013 Mr X had been symptom free for some months, although his family remained concerned that he was going out and drinking too much with friends at the weekend. They were worried this would cause him to become unwell again. At this time he had decided to take a year off his University course and work for his father.[5] At this time he was still engaged with mental health secondary care services.

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[2] Notes from interview with Mr X's Mother and Father on 30/07/2015
[3] Clinical Records page 2
[4] Clinical Records pages 3-5
[5] Clinical Records page 10

Incident Description and Consequences

3.6. On 30 March 2013 Mr X was out with a group of three friends; they had been to a friend's party and at the time of the incident were returning to Guildford by train. When they arrived at Guildford and were getting off the train, they got into an altercation with Mr Y and his friend. This altercation turned into a fight which started on the train and ended up on the station platform. During the course of the fight Mr X punched Mr Y and Mr Y fell between the platform and the train as the train began to leave the station. Mr Y died at the scene. Mr X was arrested that evening, but released into the care of his parents. Mr X was formally charged with Manslaughter in July 2013.[6] Mr X pleaded guilty to charges of Manslaughter at Guildford Crown Court on 14 December 2013 and was sentenced on 14 February 2014 to a five-year custodial sentence.[7] Mr X's legal team did not use his history of mental illness in his defence, and his parents state that at the time of the incident, although under the influence of alcohol, he was mentally well. They also stated that there was no evidence of illicit drug use in the screening completed at the Police Station when he was first arrested.[8]

4. Terms of Reference

Purpose of the investigation

5.1. To identify whether there were any gaps or deficiencies in the care and treatment that Mr X received, which could have been predicted or prevented the incident on 30 March 2013 from happening. The investigation process should also identify areas of best practice, opportunities for learning and areas where improvements to services might be required which could help prevent similar incidents from occurring.

5.2. The outcome of this investigation will be managed through corporate governance structures in NHS England, the relevant Clinical Commissioning Group and the provider's formal Board sub-committee.

Terms of Reference

5.3. Review the engagement, assessment, treatment and care that Mr X received from Surrey and Borders Partnership NHS Foundation Trust from his first referral in October 2012 up to the time he was discharged in May 2013.

5.4. Review if Mr X received or should have received a diagnosis during the time he was engaged by the services and consider the appropriateness of the pathways and treatment options he received in line with national standards and best practice.

5.5. Review if the Trust fully assessed and appreciated Mr X's drug and alcohol consumption and provided appropriate support, care and treatment options which met national standards.

5.6. Consider the safeguarding issues in relation to Mr X's alcohol and drug use in terms of self-harm and potential for harming others.

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[6] http://www.bbc.co.uk/news/uk-england-surrey-23433158, accessed on 15/09/2015

[7] http://www.thelawpages.com/ , accessed on 15/09/2015

[8] Notes from interview Mr X's mother and father on the 30/07/2015

5.7. Review the care planning and risk assessment, policy and procedures and compliance with national standards and best practice.

5.8. Review the communication between Mr X's family and the Trust including the sharing of information regarding risks to Mr X to inform risk assessment and management.

5.9. Review the Trust's internal investigation report and assess the adequacy of its findings, recommendations and implementation of the action plan and identify:

- If the investigation satisfied its own terms of reference.
- If all key issues and lessons have been identified and shared.
- Whether recommendations are appropriate, comprehensive and flow from the lessons learnt.
- Review progress made against the action plan.
- Review processes in place to embed any lessons learnt.
- Having assessed the above, to consider if this incident was predictable or preventable and deliberate on relevant issues that may warrant further investigation and comment.
- To fully assess and review the Trust's engagement with the victim and perpetrator's families, before and after the incident, including information sharing and involvement in the internal investigation, measured against best practice and national standards.

Level of investigation

5.10. **Type C:** an investigation by a team examining a single case.

Timescale

5.11. The investigation process starts when the investigator receives all the clinical records and the investigation should be completed within six months thereafter.

Initial steps and stages: **NHS England will:**

- Ensure that the victim and perpetrator families are informed about the investigative process and understand how they can be involved including influencing the terms of reference.
- Arrange an initiation meeting between the Trust, Guilford and Waverley Clinical Commissioning Group, investigator and other agencies willing to participate in this investigation (provisional dates in November/December 2014).
- Seek full disclosure of the perpetrator's clinical records to the investigation team.

Outputs

5.12. A succinct, clear and relevant chronology of the events leading up to the incident which should help to identify any problems in the delivery of care.

5.13. A clear and up to date description of the incident and any Court decision (e.g. sentence given or Mental Health Act disposals) so that the family and members of the public are aware of the outcome.

5.14. A final report that can be published, that is easy to read and follow with a set of measurable and meaningful recommendations, having been legally and quality

checked, proof read and shared and agreed with participating organisations and families (NHS England style guide to be followed).

5.15. Meetings with the victim and perpetrator families and the perpetrator to seek their involvement in influencing the terms of reference.

5.16. At the end of the investigation, to share the report with the Trust and meet the victim and perpetrator families and the perpetrator to explain the findings of the investigation.

5.17. A concise and easy to follow presentation for families.

5.18. A final presentation of the investigation to NHS England, Clinical Commissioning Group, provider Board and to staff involved in the incident as required.

5.19. We expect the investigators to include a lay person on the investigation panel to play a meaningful role and to bring an independent voice and challenge to the investigation and its processes.

5.20. We will require the investigator to undertake an assurance follow up and review, six months after the report has been published, to independently assure NHS England and the commissioners that the report's recommendations have been fully implemented. The investigator should produce a short report for NHS England, families and the commissioners and this will be made public.

5.21. We will require monthly updates and where required, these to be shared with families.

5. The Independent Investigation Team

Selection of the Investigation Team

6.1. The Investigation Team was comprised of individuals who worked independently of the Surrey and Borders Partnership NHS Foundation Trust. All professional team members retained their professional registration status at the time of the Investigation, were current in relation to their practice, and experienced in Investigation work of this nature. The individuals who worked on this case are listed below.

Independent Investigation Chair

Mr Jonathan Allen, RMN, BA(hons) MSc MBA	Senior Associate – Health and Social Care Advisory Service. Former Director of Nursing.

Investigation Team Members

Dr Androulla Johnstone	Chief Executive Health and Social Care Advisory Service. Nurse Member of panel.

Dr Elizabeth Gethins	Senior Associate – Health and Social Care Advisory Service. Consultant Psychiatrist
Mr Christopher Welton	Director – Health and Social Care Advisory Service. Lay Member

Support to the Investigation Team

Mr Greg Britton	Health and Social Care Advisory Service Investigation Manager
Mrs Fiona Shipley	Transcription Services

Independent Advice to the Investigation Team

Ms Janet Sayers	Solicitor: Kennedys

6. Identification of the Thematic Issues

Thematic Issues

6.1. Thematic issues are typically identified when either multiple cases or a case which has received multiple episodes of care over a long period of time demonstrates common issues and areas of concern over the cases or the episodes of care thus giving rise to one or more themes.

6.2. Due to the short period of care and limited level of formal psychiatric intervention received by Mr X during his time being treated by Surrey and Borders Partnership NHS Foundation Trust the Independent Investigation Team could not identify any clear thematic issues which are different from the main findings of the case.

6.3. The key themes identified by the Investigation are summarised below and will be evidenced in greater detail in the body of the report. It is important to state that there was nothing in this case that indicated that the staff could have determined that Mr X would be a risk to other people or become involved in violence. He had no previous history that would have escalated his risks beyond those of any other young person in their late teens. There were also no acts or omissions in his care and treatment that were identified as either causal or contributory to the event that transpired.

6.4. The death of Mr Y was a tragic event completely unrelated to the mental health problems Mr X had experienced. However in examining the case there were a number of service issues that the Investigation Team identified and these are provided in this report to support the process of continuous learning and quality improvement.

1. **Care Programme Approach (CPA)**
   The Care Programme Approach was not always completed to the full extent required by the Trust's own policy. CPA review meetings were, on at least one occasion, a desk top exercise and documented care plans were underdeveloped.

2. **Risk Assessment**
   Formal Risk Assessment Documentation was not fully completed or regularly reviewed and updated. On receipt of the information that Mr X had been involved in a potential Homicide there was an inadequate response by the professionals involved to ensure contact was made and risk assessments were reviewed.

3. **Referral, Transfer and Discharge Planning**
   A referral to Drug and Alcohol services was proposed but never made. Staff had said this had been declined; however this was not recorded in the clinical notes. In addition there appeared to be a lack of robust follow up on proposals to refer the case to either University Health Services or local EIIP services when Mr X returned to University in September 2013.

4. **Service User Involvement in Care Planning and Treatment**
   It is clear that the staff were sensitive to Mr X being a young adult and respected his autonomy to make decisions for himself. However during 2013 the approach appeared to over rely on Mr X to make contact and confirm all of his appointments. Prior to this it had been a collaborative approach with his mother, who helped to ensure he was available for meetings with the health team. There is no record that Mr X objected to this approach or had asked for it to be altered. The Investigation Team found that when Care Coordinator 3 took over the case a different approach was taken that was overly reliant on Mr X responding to texts and voice messages to which he did not respond. This meant Mr X was not seen by a mental health professional for more than six months despite being involved in a homicide.

5. **Carer and Family Concerns**
   The family were involved in all Mr X's early meetings, and were very supportive to his care. However it is of concern that the events of 30 March 2013 were not immediately disclosed by either the family or Mr X to the team involved in treating his mental health problems.

6. **Documentation and Professional Communication**
   Documentation of risk assessments and the Care Programme Approach was limited and not regularly updated or reviewed. In addition, from July 2013, once care coordination had transferred from Care Coordinator 2 to Care Coordinator 3, there appeared to be an over-reliance on communicating with Mr X via text and mobile telephone voicemail messages. The result was that Mr X did not have an appointment with his new care coordinator for almost six months. This six-month period followed on from the incident in which Mr X had been implicated in Mr Y's death. The treating team remained unaware as to whether or not Mr X's mental health had played a role in the death of Mr Y. The treating team had no first hand account of his current mental health or how he was coping with the stress of facing a pending Court case. The Investigation Team found it unusual that a more formal written communication was not used to support efforts at securing an appointment, and that the pre-existing relationship with Mr X's family and mother were not used to better effect.

7. **Adherence to Local and National Policy and Procedure, Clinical Guidelines**
Mr X received services almost immediately following referral from an Early Intervention Team; a good operational policy was in place at this time. The diagnostic process and medical treatment appeared in keeping with clinical guidelines for a first presentation psychosis. However the level of follow up contact and psychosocial intervention offered and provided to Mr X and his family appeared below the standard expected and hoped for. Mr X had only three appointments over the 13 months between his initial referral and being sent to prison in which anything resembling a psychosocial intervention was provided. It was unfortunate that in 12 months he had three care coordinators and three different psychiatrists involved in his care, and the level of contact (except for the initial appointments following crisis) were no more frequent than monthly. In addition no group work or psychoeducation was offered to Mr X or his family. This approach did not appear to be aligned to the national clinical guidelines for early intervention in psychosis.

Another issue of note was the lack of adherence to the Trust Clinical Risk Management policy. Significant omissions were made and whilst they did not make a contribution to the death of Mr Y they represent a service issue that indicates a review of this area is required.

8. **Clinical Governance and Performance**
There are three issues in which components of clinical governance appeared not to have functioned particularly well.

First: The handover from Care Coordinator 2 to 3 was inadequate and did not involve a recorded meeting or formal introduction. Effective planning and handover of case load should have been picked up in supervision and team meetings.

Second: the lack of formal written offers of appointments and failure to get a face-to-face meeting to re-assess risk and discover the support needs of Mr X and his family by Care Coordinator 3 for over six months appeared to be poor practice. The Independent Investigation Team questioned why this was not picked up in Supervision, via local case audits, and within team management meetings.

Third: The EIIP operational policy and Trust risk assessment policy was not adhered to. This indicates that the local clinical governance arrangements within the team ensuring cases were managed effectively and in line with policy were not working as effectively as they should have done.

7. Conclusions Regarding the Care and Treatment Mr X Received

Overview

7.1. Mr X received prompt care and treatment for a short psychotic episode from which he appeared to recover completely. He was well supported by his family and

friends who were cited as being protective factors. However some concerns about him drinking too much at weekends were raised by his mother who continued to worry about him describing on one occasion the situation being desperate. However Mr X's continued alcohol consumption did not appear to impact upon his mental health or his recovery. His continued drinking appears to have been something that he undertook as a lifestyle choice and something he refused input and support for from mental health services. As this factor did not appear to be having any impact upon his mental state and recovery there was a limited response the Early Intervention Team could make in this regard.

7.2. There were aspects of Mr X's care and treatment that on close examination could have been improved upon. These included the completeness of the care programme approach and risk assessment process – both were of a poor general standard. However none of these omissions were found to have impacted upon the tragic death of Mr Y. It was unfortunate that Mr X experienced both service and personnel continuity issues over the short period of time he was involved with the Trust. Where possible arrangements should be put in place to prevent this happening in future, although it is difficult to see what the Trust could have done differently on this occasion.

7.3. That the treating team was unable to make contact with Mr X for many months after it was known he had been involved in a homicide, was regrettable, and the Trust should consider its guidance to practitioners on the use of mobile telephones and texting as the only method of trying to make contact with service users.

Predictability and Preventability

Predictability

7.4. The Independent Investigation Team concluded that Mr X's involvement in a homicide was not predictable by mental health services. At the time of Mr Y's death Mr X was mentally well and had made a complete recovery from his psychotic episode. There was no indication to suggest that Mr X's mental state could lead him to commit an act of violence.

Preventability

7.5. The Independent Investigation Team concluded that Mr X's involvement in a homicide was not preventable by the mental health services for the same reasons as set out in paragraph 13.4.

Summary

7.6. The events that occurred leading to Mr X getting into a fight with Mr Y and Mr Y subsequently, falling between a train and the train platform and dying, was a very tragic incident, that could have been avoided by either group walking away from the other. It was coincidental that Mr X had also recently had a brief episode of mental illness, which he had appeared to recover well from. This had no bearing on Mr X's actions or behaviours on that night. His treatment and care by the professionals that were involved supported his recovery, and there is no evidence that they could have predicted or prevented the events that occurred. However as in all cases that are subject to such close scrutiny there are inevitably some opportunities for learning and service improvement. These are described in the relevant areas of the report and are listed below.

Service Issues

- ***Service Issue 1. Mr X did not receive a care and treatment package in keeping with the Trust's EIIP operational policy guidance.***
- ***Service Issue 2. Mr X did not receive his care and treatment in keeping with the Trust's Care Programme Approach.***
- ***Service Issue 3. Risk assessment and management was of a poor general quality. The Trust risk assessment policy was not followed fully and Mr X did not receive a robust level service in this regard.***
- ***Service Issue 4. Referral and transfer arrangements were of an inconsistent quality and did not adhere to the expectations set out within the EIIP operational policy.***
- ***Service Issue 5. Levels of engagement with Mr X were not sustained over time. This lack of engagement prevented ongoing assessment of Mr X and also appeared to act as a barrier to appropriate referrals being pursued with both psychological therapy and university mental health providers.***
- ***Service Issue 6. Mr X's family did not receive either education into his condition or carer assessment in a timely manner.***
- ***Service Issue 7. Levels of professional communication were inconsistent. This was of particular importance in relation to university liaison.***
- ***Service Issue 8. Trust policy and procedure was not fully adhered to in the case of Mr X. Neither supervision nor governance processes appeared to be robust enough to detect this.***
- ***Service Issue 9. Clinical governance systems were not sensitive enough to detect policy non-adherence issues.***

8. Notable Practice

8.1. **No notable practice was found.**

9. Lessons for Learning

9.1. Continuity of care is an essential factor in the development and maintenance of a therapeutic relationship. When patients are moved between services/teams and multiple changes are made to Care Coordinators and lead clinicians other processes have to work harder. In Mr X's case continuity was an ongoing factor which may have served to diminish the effectiveness of the therapeutic relationship. In this kind

of situation it is essential that written documentation and professional communication is maintained in order to ensure the continued health, safety and wellbeing of patients.

9.2. Policy adherence is an essential factor when maintaining the health, safety and wellbeing of patients. In the case of Mr X the service did not adhere to the EIIP model and neither were CPA or risk assessment processes maintained in accordance with Trust policy guidance. Whilst is has been established that Mr X was not mentally ill at the time of the death of Mr Y and there are no causal or contributory links made, Trust services must ensure that the basic building blocks of care are maintained for all patients held on the caseload.

10. Recommendations

10.1. The purpose of developing recommendations is to ensure that lessons are not only learned, but influence directly the development and management of services to ensure future patient and public safety.

17.0. The recommendations set out below have not been made simply because recommendations are required, but in order to ensure that they can improve further services and consolidate the learning from this inquiry process.

Medication and Treatment

- ***Service Issue 1. Mr X did not receive a care and treatment package in keeping with the Trust's EIIP operational policy guidance.***

Recommendation 1: The Trust should review via clinical audit processes the EIIP operational policy guidance in order to ensure compliance. The resourcing of the model should also be reviewed in order to ascertain whether any measures need to be taken.

The Care Programme Approach

- ***Service Issue 2. Mr X did not receive his care and treatment in keeping with the Trust's Care Programme Approach.***

Recommendation 2: The Trust should ensure that the EIIP Operational Policy and the Care Programme Approach policy documentation are in alignment. Work should also be undertaken to ascertain whether current EIIP patients who are on CPA require this level of input, whilst ensuring all those who are determined to require this level of service receive it in full.

Risk Assessment

- ***Service Issue 3. Risk assessment and management was of a poor general quality. The Trust risk assessment policy was not followed fully and Mr X did not receive a robust level service in this regard.***

Recommendation 3: The Trust should ensure that the EIIP Operational Policy and the Care Programme Approach policy documentation are in alignment. A review should be undertaken in the EIIP service in order to ascertain:

- the frequency of risk assessment;
- the nature of multidisciplinary risk assessment;
- whether key changes to a patient's circumstances are taken into account/trigger a re-assessment;
- whether family concerns are taken into account;
- whether the needs of siblings and children under the age of 18 are taken into full account.

Referral, Transfer and Discharge Planning

- ***Service Issue 4. Referral and transfer arrangements were of an inconsistent quality and did not adhere to the expectations set out within the EIIP operational policy.***

Recommendation 4: The Trust should develop a protocol that ensures continuity of service when clinical teams experience disruption that have a direct bearing on the quality of patient care.

Service User Involvement in Care Planning and Treatment

- ***Service Issue 5. Levels of engagement with Mr X were not sustained over time. This lack of engagement prevented ongoing assessment of Mr X and also appeared to act as a barrier to appropriate referrals being pursued with both psychological therapy and university mental health providers.***

Recommendation 5: The Trust should ensure that additional clinical guidance is given to EIIP Teams in relation to levels of assertive engagement required. The need for additional levels of engagement should always be considered when risk assessment planning has not been conducted in a regular manner and when service continuity issues are present.

Family Concerns and Involvement

- ***Service Issue 6. Mr X's family did not receive either education into his condition or carer assessment in a timely manner.***

Recommendation 6: The Trust should ensure good practice guidance in relation to families is followed (in accordance with NICE and EIIP guidance). In order to ensure structured inputs are made flags should be considered within the clinical record and audited for compliance.

Documentation and Professional Communication

- ***Service Issue 7. Levels of professional communication were inconsistent. This was of particular importance in relation to university liaison.***

Recommendation 7: The Trust should review (via clinical audit) the EIIP operational policy guidance in order to ensure compliance in relation to:

- university liaison processes;
- the quality of written documentation within the clinical record.

The Trust should also review its practice around communication with patients who do not engage with service. Whilst text messages are a useful means of communication with young people a protocol for when a more assertive approach is merited requires development.

Adherence to Local and National Policy and Procedure

- ***Service Issue 8. Trust policy and procedure was not fully adhered to in the case of Mr X. Neither supervision nor governance processes appeared to be robust enough to detect this.***

Recommendation 8: The Trust should review its clinical audit processes in relation to EIIP clinical record maintenance, CPA and risk assessment processes. This should include a review of the effectiveness of local clinical supervision.

Clinical Governance and Performance

- ***Service Issue 9. Clinical governance systems were not sensitive enough to detect policy non-adherence issues.***

See Recommendation 8 above.

Communication with Families Following the Homicide by a Mental health Service User

Recommendation 9: The Trust should ensure that the families of all victims of homicide perpetrated by service users receiving care and treatment from the Trust are managed in keeping with NHS England expectation. Families should be:

- communicated with as soon as the homicide is made known to the Trust;

- offered support, counselling and advice as appropriate;
- assigned a consistent senior liaison officer;
- are consulted with in relation to the development of internal investigation terms of reference;
- are communicated with in relation to internal investigation report findings, conclusions and recommendations;
- are given a full apology on behalf of the Trust.